STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations are the result of a Licensure Resurvey at the above named Assisted Living Facility in Topeka, Kansas on 02/23/16, 02/24/16, 02/25/16, 02/29/16, 3/01/16, 3/02/16, 3/03/16, 3/07/16, 3/08/16, and 3/09/16. Complaints #95587, #95087, #90670, and #88595 also investigated. Revised 2567 mailed to facility 3/22/2016.	S 000		
S 185 SS=D	26-39-102 (d) Admission, Transfer, Discharge (d) The administrator or operator of each adult care home shall ensure that each resident is permitted to remain in the adult care home and is not transferred or discharged from the adult care home unless one of the following conditions is met: (1) The transfer or discharge is necessary for the resident's welfare, and the resident's needs cannot be met in the current adult care home. (2) The safety of other individuals in the adult care home is endangered. (3) The health of other individuals in the adult care home is endangered. (4) The resident has failed, after reasonable and appropriate notice, to pay the rates and charges imposed by the adult care home. (5) The adult care home ceases to operate. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(d) The facility census equalled 74 the sample included six Residents, and six focused reviews completed. Based on review of record and interviews, for one of six focused reviews (#170),	S 185		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 185	Continued From page 1	S 185		

the Administrator failed to ensure each Resident permitted to remain in the adult care home and not discharged in the absence of the following: Resident's needs cannot be met, safety or health of others in home endangered, failure to pay rates and charges, or the adult care home ceases to operate.

Findings included:

- Review of record revealed #170 admitted to facility 10/11/14 with diagnoses of Dementia, Polyneuropathy, Hypertension, Hyperlipidemia, and Diabetes.

The current 5/14/15 functional capacity screen (FCS) assessed #170 in need of physical assistance with bathing, toileting, medication and treatments; independent with transfers, mobility, eating; frequently incontinent of bladder; with falls/unsteadiness, impaired decision making, and used a wheelchair.

The current 5/14/15 negotiated service agreement (NSA) documented #170 mobile by use of power chair, can transfer independently with this; custom interventions to decrease falls included staff encourage to take time with transfers; assist with bathing; assist with medications; staff empty urinal; #170 occasionally forgetful, staff will provide occasional verbal prompting to assist with orientation.

Resident Notes (RN) documented the following: 7/27/15 - 9:48am - #170 continues to use power scooter for mobility around community... continue to observe

7/30/15 - 6:38am - Resident has been placed in a manual wheelchair due to hitting another

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 185	Continued From page 2 Resident in the back x3 this week... #170 has key to power scooter... #170 able to propel this wheelchair on own... continue to observe... 8/06/15 - 12:32pm - #170 remains in the manual wheelchair at this point... has appointment with primary care physician this month and will discuss about ability to go back into the power scooter after an eval is completed... continue to observe... 8/07/15 - 5:55pm - Late Note by previous Administrator #N - "On 7/27/15 Resident came to me reporting #170 had pushed that Resident's manual wheelchair with his/her motorized wheelchair... Resident stated that he (#170) pushed into the back of the Resident's manual wheelchair 3 times on Sunday 7/26/15. This executive director went to #170 and asked what he/she did. He/she related that had pushed the Resident that complained with manual wheelchair. #170 did not seem to understand the possible danger of his/her actions. This E.D. (Executive Director) did talk to #170 and tell him/her that E.D. was removing key from #170's wheelchair until could arrange for an evaluation of #170's safety with the wheelchair. This E.D. did contact family and talked about many of the issues that #170 is having including the misuse of motorized wheelchair. E.D. has provided #170 with a manual wheelchair until can be evaluated. Family agreed with this." 8/10/15 and 8/11/15 - Notes regarding medication orders. 8/11/15 - 5:42pm - Received new order for PT/OT (physical therapy/occupational therapy) to eval and treat... Home Health here to eval today... will continue to observe	S 185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 185	Continued From page 3 The record lacked evidence of the PT/OT evaluation completed. 8/14/15 - The record contained a copy of an immediate discharge notice hand delivered to #170 on 8/14/15. This notice documented: "...#170's residency at facility must be terminated immediately after service of this notice... pursuant to Residency agreement dated 11/29/14, which states that we may terminate... if we determine in our sole and exclusive discretion that your continued presence in the Community poses an immediate threat to your health and safety or to the health and safety of other Residents at our Community or to our staff... #170 utilizes a powered scooter for mobility around the Community. On multiple occasions, #170 has driven scooter into other Residents. On July 27, 2015, I received yet another complaint from a Resident that #170 drove scooter into another Resident's wheelchair... it is imperative that you locate alternate placement immediately and within seventeen (17) of service of this Notice. The effective date of #170's termination will be August 31, 2015 unless you find new placement sooner..." Resident Notes of medical record lacked mention of this discharge notice. The next entry: 8/27/15 - 6:12am - per report Resident's family took him/her to SDC (Senior Diagnostic Center) on 8/20/15 at 7:00pm and said would not be bringing him/her back." By interview on 3/01/16 at 7:25pm, current Administrator #B and Corporate LPN (licensed	S 185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 185	Continued From page 4 practical nurse) #D stated neither here at the time of discharge notice... neither aware of why notice to terminate given to #170 on 8/14/15, for misuse of electric scooter, when scooter removed from Resident and not used by #170 since 7/27/15. The available medical record failed to demonstrate #170 endangered the safety of other Residents before 7/27/15 or after 7/27/15, considering the source of potential safety risk (motorized scooter) no longer accessible to #170. The Administrator failed to ensure #170 permitted to remain in the adult care home and not discharged in the absence of the specified conditions that warranted immediate discharge.	S 185		
S3080 SS=E	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by:	S3080		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3080	Continued From page 5 KAR 26-41-201(a)(b) The facility census equalled 74 the sample included six Residents, and six focused reviews completed. Based on review of records and interviews, for one of six sampled (#189) the Administrator failed to ensure the Functional Capacity Screen (FCS) completed for a Resident who required health care services was conducted/signed by a licensed nurse and; and for one of six focused (#172), the Administrator failed to ensure a functional capacity screen (FCS) conducted on or before admission to the facility. Findings included: - Review of record revealed #189 admitted to facility 02/06/16 with diagnoses of Dementia, Ataxia, and Incontinence of urine. The medical record contained an FCS dated 02/06/16 which documented #189 in need of assistance with bathing, dressing, toileting, medication and treatment management; in need of supervision with transfers and mobility; with "occasional to frequent" incontinence; with cognitive and communication impairments; with risk for falls, with impaired vision, hearing and decision making; and used walker. This admission FCS indicated the need for health care services, but lacked the signature of a licensed nurse. On 02/25/16 at 3:10pm Corporate Compliance Nurse #C reported no other FCS available. On 3/01/16 at 11:23 Corporate LPN (licensed practical nurse) #D confirmed no other FCS available, and the only signature on FCS that of	S3080		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3080	Continued From page 6 the Resident's family member. The Administrator failed to ensure an FCS completed for #189, who required health care services, was conducted/signed by a licensed nurse. - Review of record revealed #172 admitted to facility 02/10/15 with diagnoses of Functional decline, Glaucoma, Atrial fibrillation, Depression, Dementia, Debility, Hypertension, Spinal stenosis, Leg weakness, Loss of bladder control, and Fatigue. The medical record lacked an FCS. The Negotiated Service Agreement/Health Service Plan documented #172 needed assistance with grooming, bathing, dressing, medications, and transfers. On 02/25/16 at 3:00pm, Corporate Compliance Nurse #C reported we do not have an FCS for #172... if they ever did one it was not uploaded into the electronic record system. The Administrator failed to ensure an FCS was completed on or before admission for #172 who required health care services.	S3080		
S3082 SS=E	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form.	S3082		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3082	Continued From page 7 This REQUIREMENT is not met as evidenced by: KAR 26-41-201(d) The facility census equalled 74 the sample included six Residents, and six focused reviews completed. Based on review of records and interviews, for two of six sampled (#187 and #189) the Administrator failed to ensure designated facility staff completed a functional capacity screen (FCS) that accurately reflected the Residents's functional capacity. Findings included: - Review of record revealed #189 admitted to facility 02/06/16 with diagnoses of Dementia, Ataxia, and Incontinence of urine. The current 02/06/16 FCS assessed #189 in need of physical assistance (2) for Bathing, Dressing, Toileting, Medication and Treatment Management; Independent (0) with transfers, mobility, eating; Independent (0) crossed out and changed to (1) in need of supervision for transfers and mobility; Bladder Continence coded with a "2-3" (2=occasionally incontinent, 3=frequently incontinent); Cognition coded "1" for Short term memory; "0-1" for Long term memory; "0-1" Memory/Recall; and "1-2" for Decision Making (coding for this section is to be only a one or a zero in each category); Communication coded "0-1" Expresses information content however able, and "1-2" Ability o understand others...; with Falls/unsteadiness, Impaired vision, Impaired hearing, Impaired decision making; and "possible" hand written in for "Wandering" and used Walker.	S3082		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3082	Continued From page 8 The codes of this FCS did not accurately match the definitions of the FCS manual used to complete this assessment tool. By observations on 02/24/16 at 9:25am, #189 ambulatory around entire unit independently, without walker, from one door to another, setting off the alarms... attempted to leave multiple times. On 02/24/16 at 9:25am, Certified Medication aides #O and #P confirmed #189 constantly exit seeking and walking without assistance of walker. Behaviors/exit seeking not accurately addressed on the FCS. On 02/25/16 at 3:10pm Corporate Compliance Nurse #C reported no other FCS available. On 3/01/16 at 11:23 Corporate LPN (licensed practical nurse) #D confirmed no other FCS available, and this FCS inaccurate. The Administrator failed to ensure designated facility staff completed an FCS that accurately reflected #189's functional capacity. - Review of record revealed #187 admitted to facility 12/01/15 with diagnoses of Breast cancer with metastasis to the bone. The FCS of 11/04/15 assessed #187 Independent (0) with all care needs. The NSA/HSP (negotiated service agreement/health service plan) of 01/05/16 documented #187 to receive assistance with	S3082		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3082	Continued From page 9 medication management. The Resident Functional Needs Assessment of 01/05/16 documented #187 received bathing assistance through hospice. Resident Notes of 12/13/15, 12/14/15, 12/15/15, 12/20/15 described confusion, memory issues, and a companion care giver/sitter who stayed with Resident. On 3/01/16 at 6:12pm, Administrator #B and Corporate LPN (licensed practical nurse) #D confirmed the FCS not accurate. The Administrator failed to ensure designated facility staff completed an FCS that accurately reflected #187's functional capacity.	S3082		
S3090 SS=D	26-41-202 (c) Admission Negotiated Service Agreement (c) Each administrator or operator shall ensure the development of an initial negotiated service agreement at admission. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(c) The facility census equalled 74 the sample included six Residents, and six focused reviews completed. Based on review of records and interviews, for one of six sampled (#180), the Administrator failed to ensure the development of an initial negotiated service agreement (NSA) at admission.	S3090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3090	Continued From page 10 Findings included: - Review of record revealed #180 admitted to facility 02/06/16 with diagnoses of Progressive dementia, Chronic ulcerative colitis, Hypertension, Migraines, Parkinson's, and Hyperlipidemia. The FCS of 02/06/16 assessed #180 in need of health care services with bathing, dressing, toileting, medication and treatment management, bladder incontinence, cognition, communication, falls, and impaired decision making. The medical record lacked an NSA completed at the time of admission. The medical record contained an NSA completed on 02/10/16 by licensed practical nurse #G. This NSA not signed by the Resident's representative until 02/20/16. On 3/01/16 at 11:57am, Administrator #B and Corporate LPN (licensed practical nurse) #D confirmed #180 moved into facility on 02/06/16. Confirmed NSA not completed for #180 until 02/10/16. The Administrator failed to ensure the development of an initial NSA for #180 at admission.	S3090		
S3101 SS=E	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the	S3101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3101	Continued From page 11 resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The facility census equalled 74 the sample included six Residents, and six focused reviews completed. . Based on review of records and interviews, for three of six sampled (#189, #187, and #181), and for two of six focused reviews (#170 and #173), the Administrator failed to ensure each individual involved in the development of the NSA/HSP negotiated service agreement/health service plan, signed the agreement. Findings included: - Review of record revealed #189 admitted to facility 02/06/16 with diagnoses of Dementia, Ataxia, and Incontinence of urine. The current functional capacity screen (FCS) of "00/06/16" assessed #189 in need of health care services for bathing, dressing, toileting, medication and treatment management, bladder incontinence. The medical record contained multiple NSA/HSP's; 01/27/16, 02/09/16, and 02/10/16. Each NSA/HSP documented #189 to receive health care services, but each lacked signatures of those involved in the development of the NSA/HSP. The section "Resident/Delegating Party has been provided with a copy of this Functional needs service plan" also blank in each of the above NSA/HSP's.	S3101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3101	Continued From page 12 On 03/01/16 at 11:23am, Administrator #B, Corporate LPN (licensed practical nurse) #D, and Corporate Compliance Nurse #C verified all versions of NSA/HSP in record lacked signatures and failed to indicate a copy provided the Resident or responsible party. The Administrator failed to ensure each individual involved in the development of #189's NSA/HSP signed the agreement. - Review of record revealed #187 admitted to facility 12/01/15 with diagnoses of Breast cancer with metastasis to the bone. The FCS of 11/04/15 assessed #187 independent with all care needs. The NSA/HSP of 12/01/15 and 01/05/16 documented #187 to receive assistance with medication management and outside service provider (Resident Functional Needs Assessment also documented assistance with bathing). The NSA/HSP of 01/05/16 lacked the signature of the Resident or the Resident's representative, contained only the name of the nurse who completed. The section "Resident/Delegating Party has been provided with a copy of this Functional needs service plan" also blank in the above NSA/HSP's. On 03/01/16 at 6:12pm, Administrator #B, and Corporate LPN (licensed practical nurse) #D verified the NSA/HSP record lacked signatures and failed to indicate a copy provided the Resident or responsible party. The Administrator failed to ensure each individual involved in the development of #187's NSA/HSP signed the agreement.	S3101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3101	Continued From page 13 - Review of record revealed #181 admitted to facility 02/08/16 with diagnoses of Psychosis, Atrial fibrillation, Coronary artery disease, Hypertension, Chronic obstructive pulmonary disease. The FCS of 02/08/16 assessed #181 in need of health care services for bathing, dressing, toileting, medication and treatment management, bladder incontinence, cognitive impairment, and communication impairment. The 02/10/16 NSA/HSP documented #181 to receive health care services to address these identified needs. The NSA/HSP lacked signatures of those involved in the development of the NSA/HSP. The section "Resident/Delegating Party has been provided with a copy of this Functional needs service plan" also blank in the above NSA/HSP. On 03/01/16 at 1:42pm, Administrator #B, Corporate LPN (licensed practical nurse) #D, and Corporate Compliance Nurse #C verified all versions of NSA/HSP in record lacked signatures and failed to indicate a copy provided the Resident or responsible party. The Administrator failed to ensure each individual involved in the development of #181's NSA/HSP signed the agreement. - Review of record revealed #173 admitted to facility 11/04/15 with diagnosis of Dementia. The 11/04/15 FCS assessed #173 in need of health care services for bathing, dressing,	S3101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3101	Continued From page 14 toileting, transfers, mobility, medication and treatments, bladder incontinence, and cognition impairment. The 11/04/15 NSA/HSP documented #173 to receive health care services but signatures of those who participated in the development of the NSA/HSP. The section "Resident/Delegating Party has been provided with a copy of this Functional needs service plan" also blank in the above NSA/HSP. On 03/01/16 at 7:19pm, Administrator #B and Corporate LPN (licensed practical nurse) #D confirmed the NSA/HSP in record lacked signatures and failed to indicate a copy provided the Resident or responsible party. The Administrator failed to ensure each individual involved in the development of #173's NSA/HSP signed the agreement. - Review of record revealed #170 admitted to facility 10/11/14 with diagnoses of Dementia, Polyneuropathy, Hypertension, Hyperlipidemia, and Diabetes. The 10/11/14 FCS assessed #170 in need of health care services for bathing, medication and treatments, and bladder incontinence. The 5/14/15 and 6/30/15 NSA/HSP documented #170 to receive health care services. The 6/30/15 NSA/HSP lacked signatures of those who participated in the development of the NSA/HSP. The 5/14/15 NSA/HSP not signed until 6/20/15 by licensed nurse #I, and on 6/25/15 by family member.	S3101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3101	Continued From page 15 The section "Resident/Delegating Party has been provided with a copy of this Functional needs service plan" also blank in the above NSA/HSP. The Administrator failed to ensure each individual involved in the development of #170's NSA/HSP signed the agreement. - Review of record revealed #174 admitted to facility 12/08/15 with diagnoses of Dementia. The 12/08/15 FCS assessed #174 in need of health care services for medication and treatments. The 12/08/15 and the 01/07/16 NSA/HSP's documented #174 to receive health care services. The 01/07/16 HSP/HSP lacked the signatures of those who participated in the development. The section "Resident/Delegating Party has been provided with a copy of this Functional needs service plan" also blank in the above NSA/HSP. The Administrator failed to ensure each individual involved in the development of #174's NSA/HSP signed the agreement.	S3101		
S3165 SS=F	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(d)	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3165	Continued From page 16 The facility census equalled 74 the sample included six Residents, and six focused reviews completed. The facility identified all Residents as receiving health care services. Based on review of records and interviews for all residents of the facility,the Administrator failed to ensure the negotiated service agreement (NSA) contained the name of the licensed nurse responsible for the implementation and supervision of the health service plan (HSP). as evidenced by review of six of six sampled residents (#189, #185, #187, #180, #181, and #183), and six of six focused reviews (#170, #174, #172, #176, #178, and #173). Findings included: - Review of record revealed #189 admitted to facility 02/06/16 with diagnoses of Dementia, Ataxia, and Incontinence of urine. The current functional capacity screen (FCS) of "00/06/16" assessed #189 in need of health care services for bathing, dressing, toileting, medication and treatment management, bladder incontinence. The 02/10/16 NSA/HSP documented #189 to receive health care services but lacked the name of the licensed nurse responsible for the implementation and supervision of the plan. - Review of record revealed #187 admitted to facility 12/01/15 with diagnoses of Breast cancer with metastasis to the bone. The FCS of 11/04/15 assessed #187 independent with all care needs. The NSA/HSP of 01/05/16 documented #187 to receive assistance with medication management. The Resident Functional Needs Assessment of 01/05/16 documented #187 also received	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3165	Continued From page 17	S3165		

assistance with bathing.
The NSA/HSP documented #187 to receive health care services but lacked the name of the licensed nurse responsible for the implementation and supervision of the plan.

- Review of record revealed #185 admitted to facility 7/07/14 with diagnoses of Dementia, Depression, Dyspnea, Edema, Diabetes mellitus, Anxiety, Deep vein thrombosis, Gastroesophageal reflux disease, Hypertension, and Congestive heart failure.
The FCS of 10/28/15 assessed #185 in need of physical assistance with bathing, dressing, toileting, medication and treatment management, bladder incontinence.
The 10/28/15 and the 11/27/15 NSA/HSP documented #185 to receive health care services but lacked the name of the licensed nurse responsible for the implementation and supervision of the plan.

- Review of record revealed #183 admitted 02/28/13 with diagnoses of Dementia, Depression, Gastroesophageal reflux disease, Insomnia, Osteoarthritis, Hypertension, Coronary artery disease, and Degenerative joint disease.
The FCS of 8/14/15 and 11/12/15 assessed #183 in need of physical assistance with bathing, dressing, toileting, transfers, mobility, medication and treatment management, bladder incontinence, and cognitive impairment.
The 8/14/15 NSA/HSP documented #183 to receive health care services but lacked the name of the licensed nurse responsible for the implementation and supervision of the plan.

- Review of record revealed #181 admitted to facility 02/08/16 with diagnoses of Psychosis, Atrial fibrillation, Coronary artery disease,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3165	Continued From page 18 Hypertension, Chronic obstructive pulmonary disease. The FCS of 02/08/16 assessed #181 in need of health care services for bathing, dressing, toileting, medication and treatment management, bladder incontinence, cognitive impairment, and communication impairment. The 02/10/16 NSA/HSP documented #181 to receive health care services but lacked the name of the licensed nurse responsible for the implementation and supervision of the plan. - Review of record revealed #180 admitted to facility 02/06/16 with diagnoses of Progressive dementia, Chronic ulcerative colitis, Hypertension, Migraines, Parkinson's, and Hyperlipidemia. The FCS of 02/06/16 assessed #180 in need of health care services with bathing, dressing, toileting, medication and treatment management, bladder incontinence, cognition, communication, falls, and impaired decision making. The 02/09/16 NSA/HSP documented #180 to receive health care services but lacked the name of the licensed nurse responsible for the implementation and supervision of the plan. - Review of record revealed #178 admitted to facility 11/20/15 with diagnoses of Alzheimer's, Depression, Gout, Asthma, Chronic obstructive pulmonary disease, Dyslipidemia, and Arteriosclerotic heart disease. The FCS of 11/20/15 assessed #178 in need of health care services for medication and treatment management. The 11/20/15 NSA/HSP documented #178 to receive health care services but lacked the name of the licensed nurse responsible for the implementation and supervision of the plan.	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3165	Continued From page 19 - Review of record revealed #176 admitted to facility 8/17/07 with diagnoses of Dementia, Congestive heart failure, Benign prostatic hypertrophy, Cellulitis, Motor dysfunction, Sleep apnea, Motor dysfunction, Venous stasis, Coronary artery disease, and Hearing loss. The 9/08/15 FCS assessed #176 in need of health care services for medications and treatments. The 12/07/15 NSA/HSP documented #176 to receive health care services but lacked the name of the licensed nurse responsible for the implementation and supervision of the plan. - Review of record revealed #174 admitted to facility 12/08/15 with diagnosis of Dementia. The 12/08/15 FCS assessed #174 in need of health care services for medication and treatments. The 12/08/15 NSA/HSP documented #176 to receive health care services but lacked the name of the licensed nurse responsible for the implementation and supervision of the plan. - Review of record revealed #173 admitted to facility 11/04/15 with diagnosis of Dementia. The 11/04/15 FCS assessed #173 in need of health care services for bathing, dressing, toileting, transfers, mobility, medication and treatments, bladder incontinence, and cognition impairment. The 11/04/15 NSA/HSP documented #173 to receive health care services but lacked the name of the licensed nurse responsible for the implementation and supervision of the plan. - Review of record revealed #172 admitted to facility 02/11/15 with diagnoses of Dementia, Functional decline, Glaucoma, Atrial fibrillation, Depression, Debility, Hypertension, Spinal	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3165	Continued From page 20 stenosis, Loss of bladder control, Fatigue, and Hyperpotassemia. The 02/11/15 FCS assessed #172 in need of health care services for bathing, dressing, toileting, transfers, mobility, medication and treatments, bladder incontinence, and cognition impairment. The 02/11/15 NSA/HSP documented #172 to receive health care services but lacked the name of the licensed nurse responsible for the implementation and supervision of the plan. - Review of record revealed #170 admitted to facility 10/11/14 with diagnoses of Dementia, Polyneuropathy, Hypertension, Hyperlipidemia, and Diabetes. The 10/11/14 FCS assessed #170 in need of health care services for bathing, medication and treatments, and bladder incontinence. The 6/30/15 NSA/HSP documented #170 to receive health care services but lacked the name of the licensed nurse responsible for the implementation and supervision of the plan. On 3/01/16 at 3:10pm, Corporate Compliance Nurse #C, Administrator #B, and Corporate LPN (licensed practical nurse) #D stated not aware of the requirement to have the actual name of the nurse responsible on the NSA/HSP... thought it was acceptable to just have a nurse sign the form.	S3165		
S3171 SS=E	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice.	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 21 This REQUIREMENT is not met as evidenced by: KAR 26-41-204(i) The facility census equalled 74 the sample included six Residents, and six focused reviews completed. The facility identified all Residents as receiving health care services. Based on review of records and interviews, for four of six sampled (#185, #180, #181, and #183), and for two of six focused reviews (#170 and #176), the Administrator failed to ensure all health care services provided by qualified staff in accordance with acceptable standards of practice. Findings included: - Review of record revealed #183 admitted 02/28/13 with diagnoses of Dementia, Depression, Gastroesophageal reflux disease, Insomnia, Osteoarthritis, Hypertension, Coronary artery disease, and Degenerative joint disease. The functional capacity screens (FCS) dated 8/14/15 and 11/12/15 assessed #183 in need of physical assistance with bathing, dressing, toileting, transfers, mobility, medication and treatment management, bladder incontinence, short term memory and memory recall impairments, communication impairment (rarely or never understands), with falls/unsteadiness, and used a wheelchair. The negotiated service agreement/health care service plan (NSA/HSP) dated 8/14/15 recorded services that included: encouraged to use call pendent for needed assistance; staff provide complete grooming, bathing, and dressing, assistance; staff to manage medications and treatments; staff will provide supervision and/or	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 22	S3171		

cueing for transfers, encourage to use pendent to notify nursing of needed assistance to help prevent falls; staff will assist to bathroom as needed through the day/night; adjustable foot drop brace to be on in a.m. (morning) and off at bedtime; staff will propel wheelchair to meals; provide occasional verbal prompting for orientation and documented outside therapy provider. The NSA/HSP dated 11/12/15 documented the same interventions except the outside therapy provider no longer listed.

Resident Notes:

3/20/15 - 7:46pm - already in chair... stated slipped off couch... fell on buttocks... no pain or discomfort

4/03/15 - 4:32am - found on floor... insisted not hurt, does not know what happened... assessment, no injuries noted... assisted back to bed

4/04/15 - 2:13pm - Resident has had 3 falls in the past 24 hours... stated not in pain, no noticeable injuries... very confused and not at normal level of functioning... sent to hospital to assess for possible UTI (urinary tract infection)

Medical record lacked evidence of licensed nurse assessment of #183 at the time of three falls, at time of transfer to hospital.

5/04/15 - 3:00pm - returned to facility

Medical record lacked evidence of licensed nurse assessment of #183 at time of return to facility from hospital, and no noted reason for admission and length of stay in hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 23 5/10/15 - 5:50 pm - slipped out of bed, stated did not hit head, encouraged to call for help Medical record lacked evidence of licensed nurse assessment at time of fall 7/03/15 - 12:41pm - pushed assist button... staff found on floor of bedroom... complained of right hip pain, nurse to room, Resident alert and awake, right leg turned out laterally...transported to hospital 7/07/15 - 5:39pm - admitted to hospital with diagnosis of hip fracture 8/03/15 - 3:49pm - spoke with rehab... hoping #183 ready to come back in about a week... Medical record lacked evidence of licensed nurse assessment at time of #183's 8/14/15 return to facility 8/15/15 - 8:00am - Resident out of Levo 500mg and Oxycodone 5mg doses... none given at 8am or 8pm 8/16/15 - 8:00am - Resident out of Levo 500mg and Oxycodone 5mg doses... none given at 8am or 8pm Medical record lacked evidence of licensed nurse attempt to clarify order or to resolve missing medications 8/25/15 - 3:53pm - APRN (advanced practice registered nurse) order for LSCSW (licensed specialist clinical social worker) evaluation related to depression, dementia... 9/16/15 - 8:14am - seen by APRN... please check	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 24 to see if patient has been evaluated/seen by LSCSW (ordered 8/25/15)... 9/17/15 - 12:18pm - fax sent for LSCSW The medical record lacked evidence that evaluation or visit by LSCSW completed, or order discontinued 10/27/15 - 6:53pm - APRN visit with order for "weekly arm circumference measurement" for weight loss surveillance. Review of the MAR (medication administration record) documents weekly measurements in October, November, December. January and February 2016 MAR lacked documentation of weekly measurements. Review of medical record lacked documentation of an order to discontinue weekly arm circumference measurement.. 11/14/15 - 12:15pm - found on floor in shower... fell from toilet... complained of knee... bruising... also complaining hurt chest... head not hit but hurting... yelled when put on AMR (American medical response) gurney... took him/her out with the ambulance... Medical record lacked evidence of licensed nurse assessment at time of #183's 11/19/15 return to facility 12/31/15 - 2:30pm - called to room at 1:40pm... Resident laying on floor on back, knees bent... pain in back... vitals obtained, assisted to toilet... did complain of right hip pain... sent to emergency room...	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 25 12/31/15 - 7:24pm - admitted to hospital... compression fracture T6 (thoracic vertebrae 6) 01/05/16 - 8:03pm - Resident returned to facility on 01/02/16... reported having increased pain related to T6 fracture... seen today by APRN... Oxycodone doubled... Medical record lacked evidence of licensed nurse assessment at time of #183's 01/02/16 return to facility and lacked documentation that hospital discharge orders were implemented. 01/18/16 - 7:28am - discharge paperwork from 12/31/15 found for this Resident with orders that have not been completed... note to physician... antibiotic was to be started at time of discharge, never started... 6:40pm still awaiting return fax from physician... 01/19/16 - 2:57am - please follow up with APRN on rounds today 01/19/16 - 4:54pm - front desk staff told Certified Medication Aide about Resident being outside in cold... staff went to check on Resident... "confused and wanted to go home"... redirected back to room... APRN starting antibiotics (that were to be started at time of hospital discharge)... to be continued on hourly checks... Medical record lacked evidence of licensed nurse assessment at time Resident outside in the cold. 01/21/16 - 1:40pm - Cipro ordered on 01/19/16 (originally ordered 01/02/16) not yet received and not yet started... pharmacy stated had not received order... APRN requested hourly checks	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 26 continue because going outside and confusion not typical for Resident... ordered from pharmacy and first dose administered at 8pm... 01/27/16 - 7:10pm - UA (Urinalysis) to be collected 72 hours after antibiotic finished... 02/10/16 - 3:02pm - UA needs to be collected... finished Cipro 01/28/16... Medical record failed to describe why UA order not followed on 01/31/16, and when UA ultimately obtained 02/13/16 - 5:09pm - Resident sitting on floor at foot of bed... stated slid down.. only one break on the wheelchair locked... assessed... no injury noted, denies hitting head on floor... Medical record lacked evidence of licensed nurse assessment at time Resident found on floor. 02/23/16 - 6:31pm - Resident anxious, agitated, unable to redirect, wanted to see parents... sent to hospital for acute change in mentation... returned to facility at 7:20pm... Medical record lacked evidence of licensed nurse assessment at time Resident returned to facility. Interviews of Corporate Compliance Nurse #C, Administrator #B, and Corporate LPN (licensed practical nurse) #D on 3/01/16 from 2:39pm through 4:53pm revealed no one sure why assessments by licensed nurses not documented, why orders for medications, labs, LSCSW evaluation not followed or discontinue orders documented. The Administrator failed to ensure all health care services, including licensed nurse assessment and order implementation for Resident #183 not provided by qualified staff in accordance with acceptable standards of practice.	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 27 - Review of record revealed #181 admitted to facility 02/08/16 with diagnoses of Psychosis, Atrial fibrillation, Coronary artery disease, Hypertension, Chronic obstructive pulmonary disease. The FCS of 02/08/16 assessed #181 in need of health care services for bathing, dressing, toileting, medication and treatment management, bladder incontinence, cognitive impairment, communication impairment, with Impaired decision making, with Falls/unsteadiness, and used walker. The 02/10/16 NSA/HSP documented #181 to receive health care services to address these identified needs. This NSA/HSP printed from the electronic record system, not available in physical chart, and not signed by Resident, staff, or family. Resident Notes: 02/08/16 - 4:40pm - Resident arrived to community around 2:45pm on the medical bus escorted by a facility staff member. Resident is happy and seems to be taking the transition well... family here visiting. Medical record lacked evidence of licensed nurse assessment at time of Resident's admission. 02/12/16 - 6:00pm - #181 sitting upright against the wall in hallway outside room... reports lost balance turning with walker while leaving room... felt like "whiplash", neck and hips hurting... transported to hospital... returned at approximately 10:00pm... family brought back... Medical record lacked evidence of licensed nurse assessment at time of return from hospital, any diagnosis or follow up interventions.	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 28 02/10/16 NSA/HSP intervention to address fall risk: "Staff will provide custom interventions to decrease fall risk." Medical record lacked evidence of what custom interventions used to decrease #181's fall risk, before or after 02/12/16 fall in hallway. On 3/01/16 at 1:42pm, Corporate LPN (licensed practical nurse) confirmed NSA/HSP not completed at time of admission, not reviewed or revised after fall on... reviewed task sheets for new interventions and confirmed at 2:07pm, none available. The Administrator failed to ensure all health care services, including licensed nurse assessment and development of new care interventions for #181, by qualified staff in accordance with acceptable standards of practice. - Review of record revealed #170 admitted to facility 10/11/14 with diagnoses of Dementia, Polyneuropathy, Hypertension, Hyperlipidemia, and Diabetes. The 10/11/14 FCS (functional capacity screen) and the 5/14/15 FCS assessed #170 in need of health care services for assistance with bathing, supervision with toileting, medication and treatment management, bladder incontinence, with short term memory impairment, impaired vision, impaired hearing, and used wheelchair. The 5/14/15 NSA/HSP documented health care services for #170: Staff will provide custom interventions to decrease fall risk, encouraged to take time with transfers; assist with bathing; provide medication management; staff assist with	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 29	S3171		

setting up and emptying the commode/urinal; occasional verbal prompting for orientation; observe ability to self manage diabetic care.

The 6/30/15 NSA/HSP documented health care services for #170: Staff will provide custom interventions to decrease fall risk; encouraged to push pendant for assistance with transferring and to the bathroom; staff provide assistance with showers; staff work to enhance communications to assure needs being understood; staff to manage medications; stand by assistance... staff to assist Resident with transfers; staff assist to bathroom day/night; staff provide occasional observation of Resident for safety and interactions with staff and other Residents; occasional verbal reminders for orientation; observe for self management of diabetes; status checks twice per shift.

Resident Notes:
11/05/14 - 12:45pm - on 11/14/14 staff responded to lifeline... lying on left side in bathroom... sated in a rush to get to toilet and lost balance... non skid strips placed in Resident bathroom...
01/06/15 - 5:47pm - on floor dining area... stated trying to move chair and lost balance, fell backwards... laceration to back of head... pressure applied... assessment completed... transported to hospital... returned from hospital with staples to laceration with orders for care and removal... staff to monitor hourly...
The medical record lacked an assessment by licensed nurse at time of return from hospital.

3/02/15 - 4:02pm - order for UA (urinalysis) to rule out UTI (urinary tract infection) for Resident's recent odd behavior
Medical record lacked an assessment or description of recent odd behaviors and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 30 interventions attempted Medical Record contained a 4/07/15 Emergency Department encounter record. Encounter documented Resident evaluation with CT scan of head, electrocardiogram, and X-ray of knee, resulting diagnosis of "Contusion of face and Simple bruising" from fall. This event not documented in Resident Notes. Medical record lacked an assessment by a licensed nurse of #170 at time of fall, when and how transported to hospital, when and how returned from hospital. 4/16/15 - 9:15am - found just inside of doorway on back... no obvious signs of injury... reported was leaning forward trying to plug up scooter when lost balance and fell backwards...said hit head "just barely" on closet door... had a "lump" on right medial lower back... examined head and back... checked again later... 5/05/15 - 2:23pm - found on floor in apartment... not wearing call button... states was going from wheelchair to bed when lost balance and fell... states when hit head on floor "blacked out"... left by AMR (American medical response) 5/16/15 - 8:10pm - found on floor in room after call from a staff member... no apparent injury... refused to be transported by AMR... told to please put pendent on for help when wants to get out of bed... 5/16/15 - 10:00pm - neighbor call to say #170 calling for help... found on floor... no apparent injury... able to move extremities, pupils equal round reactive to light... 5/19/15 - 7:51am - found on floor... said trying to get out of bed to eat breakfast... denies pain... 5/21/15 - 11:02am - phone call from a Resident nearby... yelling from #170's apartment... found lying on floor... stated was trying to get out of	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 31	S3171		

bed... doesn't know if lost balance or what... been this way for hours
5/25/15 - 5:29pm - called by staff member... #170 on floor... stated was getting out of bed and fell on floor... assessment completed... asked to please put pendent on for help when trying to get up and down from bed and electric chair...
6/14/15 - 11:30pm - called to room... sitting on floor leaning against bed... no injury noted... denies pain/discomfort
6/15/15 - 4:20pm - sent to emergency room by APRN (advance practice registered nurse) for dehydration...
Medical record lacked an assessment by a licensed nurse for most of these instances, and lacked evidence new interventions considered or attempted to prevent further falls

6/22/15 - 9:35am - found on floor by support staff... trying to use restroom and don't know what happened... not wearing call pendant... did not have injuries or bleeding... denies hit head or pain
6/22/15 - 9:44am - staff to be available upon Resident waking to prevent future falls... amended NSA complete, family notified by voice message
7/23/15 - 10:02am - today at 5:10am staff responded to Resident's call light... noted lying flat on floor beside AC unit... doesn't know what he/she was doing or what caused fall... laceration to back of head... transferred to hospital... reminded to use call light for assistance...
Medical record lacked an assessment by a licensed nurse upon return from the hospital, and lacked evidence new health care services added to 6/30/15 NSA/HSP provided

By review, #170's medical record contained cost of supportive services increase on 5/14/15, and again on 6/30/15. The medical record failed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 32 demonstrate Resident received increased services, and continued to experience repetitive falls. On 3/01/16 at 7:19pm, Administrator #B and Corporate LPN (licensed practical nurse) stated neither were in facility at that time, and did not know reasons for staff failure to provide health care services. The Administrator failed to ensure all health care services, including licensed nurse assessment and development of new care interventions for #170, by qualified staff in accordance with acceptable standards of practice. - Review of record revealed #180 admitted to facility 02/06/16 with diagnoses of Progressive dementia, Chronic ulcerative colitis, Hypertension, Migraines, Parkinson's, and Hyperlipidemia. The FCS of 02/06/16 assessed #180 in need of health care services with bathing, dressing, toileting, medication and treatment management, bladder incontinence, cognitive impairment, communication impairment, falls/unsteadiness, and impaired decision making. The 02/09/16 NSA/HSP documented #180 to receive health care services to address these identified health care needs. Resident Notes - First entry: 02/09/16 - 2:18pm - medication clarification received back from physician Medical record lacked evidence of an admission assessment and note completed by a licensed nurse at time of admission to facility.	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 33 On 3/01/16 at 11:57am, Corporate Compliance nurse #C confirmed #180 entered facility on 02/06/16... not able to determine why admission assessment and note not completed by the licensed admitting nurse. The Administrator failed to ensure all health care services, including licensed nurse admission assessment and note regarding #180, by qualified staff in accordance with acceptable standards of practice. - Review of record revealed #176 admitted to facility 8/17/07 with diagnoses of Dementia, Congestive heart failure, Benign prostatic hypertrophy, Cellulitis, Motor dysfunction, Sleep apnea, Motor dysfunction, Venous stasis, Coronary artery disease, and Hearing loss. The 9/08/15 FCS assessed #176 in need of health care services for medications and treatments, with short term memory and memory recall impairment, with falls/unsteadiness, and used wheelchair. The 9/08/15 and 12/07/15 NSA/HSP's documented #176 to receive health care services for fall risk (staff will provide custom interventions, monitor non skid strips by bed); medications (assist with ordering medications); and behaviors (occasional observation for safety and interactions with staff and others... observe for changes and report... has made inappropriate sexual statements towards others). The NSA/HSP lacked specific interventions to address this Resident's behaviors. (9/08/15 NSA/HSP documented #176 receiving Depo injection monthly due to sexual behavior, but did not	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 34 indicate who administered the injection). Resident Notes: 5/06/15 - 6:00am - found on bathroom floor... unable to state what happened, how it happened, how long on floor... AMR (American medical response) called to assist off floor... refused to be transported to hospital 5/06/15 - 10:11am - called to apartment due to confusion... #176 hard to keep awake, did not know what was going on and very confused overall... family stated needs to go to hospital... AMR came to get... 5/12/15 - 7:37am - spoke to rehab... admitted for Atrial fibrillation and rehab... will call closer to discharge so facility can come assess... 6/03/15 - 12:30pm - returned to facility from rehab. Medical record lacked evidence of an assessment by a licensed nurse upon return to facility. 7/21/15 - 1:14pm - APRN (advance practice registered nurse) here to see Resident... new orders for injection medication every month for sexual behaviors... (no behaviors or interventions to address behaviors documented) 8/11/15 - 1:41pm - APRN here to see Resident, spoke with family member regarding continuing sexual behaviors (no behaviors or interventions to address behaviors documented) 12/10/15 - 6:22pm - to Resident's room... observed kissing the Resident... 12/30/15 - 1:32pm - #176 was found in Resident's room after instructed by staff to not follow that Resident to room... Medical record lacked evidence of revisions or additional interventions to the NSA/HSP to	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 35 address Resident's behaviors. On 3/01/16 at 5:48pm, Administrator #B and Corporate LPN (licensed practical nurse) #D confirmed NSA/HSP lacked specific interventions... confirmed the FCS also failed to address behaviors as an identified need. The Administrator failed to ensure all health care services, including licensed nurse admission assessment and note regarding #176, by qualified staff in accordance with acceptable standards of practice.	S3171		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by:	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3200	Continued From page 36 KAR 26-41-205(d) The facility census equalled 74 the sample included six Residents, and six focused reviews completed. The facility identified all Residents as receiving medication management. Based on review of records and interviews, for five of six sampled (#185, #187, #180, #181, and #183), and for one of six focused reviews (#172), the Administrator failed to ensure all medications and biologicals administered to Residents in accordance with a medical care provider's written orders and in accordance with professional standards of practice. Findings included: - Review of record revealed #172 admitted to facility 02/11/15 with diagnoses of Dementia, Functional decline, Glaucoma, Atrial fibrillation, Depression, Debility, Hypertension, Spinal stenosis, Loss of bladder control, Fatigue, and Hyperpotassemia. The 02/11/15 FCS assessed #172 in need of medication and treatment management. The 02/11/15 NSA/HSP documented #172 to receive medication and treatment management. Review of record revealed: According to Resident Notes #172 arrived at facility on 02/11/15 at 12:00pm. According to MAR (medication administration record) of February 2015, Travatan (glaucoma and ocular hypertension) ordered daily at 8pm, administered daily at 8am (web site for Travatan also specifies bedtime administration, and re-ordered on 02/25/15 at bedtime, but continued at 8am until 3/18/15)	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3200	Continued From page 37 Aricept (Alzheimer's medication) ordered daily at 8am not started until 02/14/15 Combigan eye drops (for glaucoma) ordered daily 8am and 8pm not started until 8am on 02/12/15 Cozaar (blood pressure) ordered daily 8am not started until 8am on 02/14/15 Lexapro (depression) ordered daily 8am not started until 8am on 02/13/15 Lumigan (glaucoma) eye drops ordered daily 8am not started until 8am on 02/13/15 Tylenol (pain) ordered three times daily 8am, 2pm, 8pm; not started until 8pm 02/12/15 Zocor (cholesterol) ordered daily at 8am not started until 8am 02/13/15 Pred Forte (topical anti inflammatory) eye drops ordered 02/25/15 to be given every four hours; not started until 8am on 02/26/15 Women's multivitamin ordered 3/04/15 daily at 8am not started until 3/07/15 Nystatin powder ordered 4/02/15 twice daily, not added to MAR until 4/10/15, never started or administered according to the April 2015 MAR. On 3/01/16 at 6:40pm, Administrator #B and Corporate LPN (licensed practical nurse) #D confirmed documentation demonstrated medications not administered as ordered by physicians... neither at facility February to April of 2015 and neither aware of the reasons. The Administrator failed to ensure all medications administered to #172 in accordance with written medical care provider orders, and in accordance with professional standards of practice. - Review of record revealed #187 admitted to facility 12/01/15 with diagnoses of Breast cancer with metastasis to the bone.	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3200	Continued From page 38 The FCS of 11/04/15 assessed #187 Independent (0) with medication management. The NSA/HSP of 12/01/15 did not address medication management. The NSA/HSP's of 01/05/16 documented #187 to receive assistance with medication management. Comparison of the February 2016 MAR (medication administration record) with signed medical care provider orders revealed discrepancies; Tylenol 650mg tablet take one tablet by mouth every 6 hours as needed for pain/fever, dated 01/27/16 on the MAR; documented as administered on 02/10/16; unable to locate written, signed order for this medication. Zofran 4mg (milligrams) tablet take one by mouth three times a day as needed for nausea; not dated on MAR, and no written medication order located Cipro 250mg tablet take one by mouth twice a day for 5 days for urinary tract infection; this medication ordered by physician on 02/11/16 at 1:40pm. Medication not started until 8:00pm on 02/12/16 On 3/01/16 at 1:35pm, Certified medication aide #Q stated #187 was very confused... initially took meds from box that hospice filled then we started giving them. On 3/01/16 at 6:12pm, Administrator #B and Corporate LPN (licensed practical nurse) #D stated not able to provide documentation of signed orders or to explain why antibiotic not started the day it was ordered. The Administrator failed to ensure all medications administered to #187 in accordance with written medical care provider orders, and in accordance	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3200	Continued From page 39 with professional standards of practice. - Review of record revealed #180 admitted to facility 02/06/16 with diagnoses of Progressive dementia, Chronic ulcerative colitis, Hypertension, Migraines, Parkinson's, and Hyperlipidemia. The FCS of 02/06/16 assessed #180 in need of medication and treatment management. The 02/09/16 NSA/HSP documented #180 to receive medication and treatment management. Comparison of the 01/27/16 written medical care provider orders with February 2016 MAR (medication administration record) revealed discrepancies: Admitted to facility 02/06/16, but medications not started until: MOM (milk of magnesia) ordered daily, not started until 02/09/16 Mirtazapine (depression) ordered daily at bedtime, not started until 02/08/16 Prednisolone (eye anti inflammatory) twice daily, not started until 8pm on 02/09/16 Donepezil (Alzheimer's) ordered dailly at bed time, not started until 02/09/16 Artificial tears (eye dryness) ordered twice daily, not started until 02/08/16 Atorvastatin (cholesterol) ordered daily not started until 02/08/16 Azilect (Parkinson's) ordered daily, not started until 02/09/16 Carbidopa-Levodopa ordered four times daily, not started until 4pm 02/08/16 Docusate (stool softener) ordered twice daily, not started until 8pm 02/08/16 Famotidine (stomach acid) ordered twice daily,	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3200	Continued From page 40 not started until 8pm 02/08/16 MOM suspension 15ml (milliliters) by mouth daily per written, signed order; MAR documented MOM 15ml administered to #180 twice daily from 02/09/16 through 02/19/16. Hydrocodone-acetaminophen 10/325 one tablet for pain, maximum dosage six in 24 hours, per written, signed order; MAR lacked this order; no evidence medication discontinued Loperimide 0.5mg (milligrams) for loose stools, maximum dosage six in 24 hours, per written, signed order; MAR lacked this order; no evidence medication discontinued Acetaminophen 325mg (milligrams) for head ache or fever, maximum dosage 650mg three times daily, per written order, signed order; MAR lacked this order; no evidence medication discontinued On 3/01/16 at 12:17pm, Corporate Compliance Nurse #C stated the MOM discrepancy was found in an audit or MAR check... not sure who put medication orders on MAR from the written signed orders. On 3/01/16 at 12:41pm, Corporate Compliance Nurse #C stated per our policy, we try not to have PRN (as needed) medications in "Life Guidance" (memory impairment unit)... confirmed with #C and Corporate LPN (licensed practical nurse) #D no evidence of written order to discontinue PRN medications Hydrocodone, Loperimide, and Acetaminophen... no evidence of clarification with medical care provider to remove these medications from MAR/order list. The Administrator failed to ensure all medications administered to #180 in accordance with written medical care provider orders, and in accordance	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3200	Continued From page 41 with professional standards of practice. - Review of record revealed #185 admitted to facility 7/07/14 with diagnoses of Dementia, Depression, Dyspnea, Edema, Diabetes mellitus, Anxiety, Deep vein thrombosis, Gastroesophageal reflux disease, Hypertension, and Congestive heart failure. The FCS of 10/28/15 assessed #185 in need of medication and treatment management. The 10/28/15 NSA/HSP documented #185 to receive medication and treatment management. Review of the medical record revealed an 02/12/16 physician's order for Cephalexin 500mg twice daily for 10 days. Review of the 02/2016 MAR (medication administration record) revealed this medication not started until 8:00pm on 02/14/16. On 3/01/16 at 4:52pm, Corporate Compliance nurse #C, Administrator #B, and Corporate LPN (licensed practical nurse) #D not aware of why medication not started when ordered on 02/12/16. The Administrator failed to ensure all medications administered to #185 in accordance with written medical care provider orders and in accordance with professional standards of practice. - Review of record revealed #183 admitted 02/28/13 with diagnoses of Dementia, Depression, Gastroesophageal reflux disease, Insomnia, Osteoarthritis, Hypertension, Coronary artery disease, and Degenerative joint disease.	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3200	Continued From page 42	S3200		

The FCS of 8/14/15 and 11/12/15 assessed #183 in need of physical assistance with medication and treatment management.

The 8/14/15 NSA/HSP documented #183 to receive medication and treatment management.

Review of record revealed Resident returned to facility from hospital on 01/02/16. Written orders sent with Resident from hospital not noted or initiated at that time.
These orders included Ciprofloxacin 250mg twice daily for 10 doses; Discontinue of Voltaren gel and Benadryl extra strength cream.

On 01/18/16 at 7:28am, licensed nurse #G documented in Resident Notes, the written medication orders discovered and notification sent to the physician.

Review of record revealed #183 returned to facility from rehabilitation on 8/14/15. The Resident Notes documented 8/15/15 and 8/16/15 "Resident out of Levo 500mg and Oxycodone 5mg doses none given at 8am or 8pm."
The record lacked the reason these medications not available and not administered, lacked any attempts to rectify the unavailability, and any lacked communication with the physician that Resident not receiving medications, in accordance with professional standards of practice.

On 3/01/16 at 4:33pm Corporate Compliance Nurse #C and Corporate LPN (license practical nurse) #D reviewed available records and confirmed no evidence written orders noted or initiated by staff when #183 returned from hospital... stated unable to tell if a facility nurse or an agency nurse was working when Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3200	Continued From page 43 returned from hospital on 01/02/16... confirmed no documentation available to address medications not given 8/15/15 and 8/16/15. The Administrator failed to ensure all medications administered to #183 in accordance with written medical care provider orders, and in accordance with professional standards of practice. - Review of record revealed #181 admitted to facility 02/08/16 with diagnoses of Psychosis, Atrial fibrillation, Coronary artery disease, Hypertension, Chronic obstructive pulmonary disease. The FCS of 02/08/16 assessed #181 in need of medication and treatment management. The 02/10/16 NSA/HSP documented #181 to receive medication and treatment management. Comparison of the February 2016 MAR (medication administration record) with written physician orders of 02/18/16 revealed discrepancies. Miconazole 2% powder apply under breasts as needed for skin infection due to candida yeast Trazadone 50mg (milligrams) by mouth at bedtime as needed for sleep Albuterol 0.083% nebulizer solution inhale into lungs every 2 hours as needed for wheezing Bisacodyl 10mg suppository rectally daily as needed for constipation Bisacodyl 5mg enteric coated tablet take two by mouth daily as needed for constipation Refresh eye drops one drop twice daily as needed for irritation and dry eyes Nitroglycerin 0.4mg under the tongue every five minutes as needed for chest pain	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3200	Continued From page 44 Promethazine-codeine 6.25-10mg/5ml (milliliters) every 4 hours as needed for cough On 3/01/16 at 12:41pm, Corporate Compliance Nurse #C stated per our policy, we try not to have PRN (as needed) medications in "Life Guidance" (memory impairment unit)... confirmed with #C and Corporate LPN (licensed practical nurse) #D no evidence of written order to discontinue PRN (as needed)medications, and no evidence of clarification with physician to remove these medications from MAR/order list. The Administrator failed to ensure all medications administered to #185 in accordance with written medical care provider orders, and in accordance with professional standards of practice.	S3200		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility census equalled 74 the sample included six Residents, and six focused reviews completed. Based on reviews of records and interviews, for four of six sampled (#189, #180, #183, and #181), and for two of six focused reviews (#172 and #176), the Administrator failed	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3261	Continued From page 45	S3261		

to ensure each Resident record contained documentation of all incidents, symptoms and other indications of illness or injury, including the date, time of occurrence, action taken, and results of the action.

Findings included:

- Review of record revealed #172 admitted to facility 02/11/15 with diagnoses of Dementia, Functional decline, Glaucoma, Atrial fibrillation, Depression, Debility, Hypertension, Spinal stenosis, Loss of bladder control, Fatigue, and Hyperpotassemia.

The 02/11/15 FCS assessed #172 in need of health care services for bathing, dressing, toileting, transfers, mobility, medication and treatments, bladder incontinence, and cognition impairment.

The 02/11/15 NSA/HSP documented #172 to receive health care services to address these identified health care needs.

Review of Resident Notes and physician orders from 02/11/16 to 4/14/16 revealed multiple (at least seven) orders for an assortment of eye drop medications. The medications included those for glaucoma, ocular hypertension, and anti inflammatory medications. The physician orders for eye interventions were issued by the primary care physician, and by the ophthalmologist.

The medical record lacked documentation of eye assessment, signs, symptoms, dates, and times. The Resident Notes included the arrival of new orders, but lacked detail of new or current symptoms that prompted the newer orders or the order changes. The admission diagnoses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3261	Continued From page 46	S3261		

included "unspecified Glaucoma" and the final physician visit of 4/13/15 documented "chronic eye lesion with various drops which have not been effective."

On 3/01/16 a 6:40pm, Administrator #B and Corporate LPN (licensed practical nurse) #D confirmed no documentation of eye symptoms and decline in medical record... stated neither were in facility at time of #172's stay.

The Administrator failed to ensure #172's record contained documentation of all symptoms and other indications of illness, including the date, time of occurrence, action taken, and results of the action.

- Review of record revealed #189 admitted to facility 02/06/16 with diagnoses of Dementia, Ataxia, and Incontinence of urine.

The current functional capacity screen (FCS) of "00/06/16" assessed #189 in need of physical assistance with bathing, dressing, toileting, medication and treatment management; in need of supervision with transfers and mobility; with bladder incontinence, cognitive and communication impairment; with falls/unsteadiness, impaired vision, hearing, decision making; wandering "possible" and "used walker."

The 02/10/16 NSA/HSP documented #189 to receive health care services to address these identified health care needs.

On 02/24/16 at 9:25am, Certified Medication Aides #O and #P stated behaviors include exit seeking... adamant he/she wants out... have to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3261	Continued From page 47	S3261		

redirect away from the doors... will sometimes use walker, but may be more at risk with it than without it... will usually sit still for a little bit in an activity... but even on bus rides, insists driver should stop and let off at specific streets... always exit seeking...

On 02/24/16 at 9:25am, #189 ambulated independently length of South hall... set off alarm at South entrance... then proceeded to ambulate North hall and set off that alarm... a short time later observed at the East hall entrance door, preparing to try to open it.

By review of record, Resident Notes:
02/06/16 - 12:51pm - arrived with family at 11:30am... in dining room eating lunch.
Medical record lacked an admission "arrival" and "assessment" note to define the status of Resident at time of admission (orientation, vitals, skin condition, ambulatory status, mode of arrival, persons accompanying Resident, response to admission, and other pertinent observations).

02/06/16 to 3/01/16 Resident Notes lacked any documentation of exit seeking behavior, times, dates, actions taken, and the results of the actions.

The Administrator failed to ensure #189's record contained documentation of all incidents, symptoms and other indications of illness or injury, including the date, time of occurrence, action taken, and results of the action.

- Review of record revealed #181 admitted to facility 02/08/16 with diagnoses of Psychosis, Atrial fibrillation, Coronary artery disease, Hypertension, Chronic obstructive pulmonary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3261	Continued From page 48	S3261		

disease.

The FCS of 02/08/16 assessed #181 in need of health care services for bathing, dressing, toileting, medication and treatment management, bladder incontinence, cognitive impairment, and communication impairment.

The 02/10/16 NSA/HSP documented #181 to receive health care services to address these identified health care needs.

By review of record, Resident Notes:
02/08/16 - 4:40pm - arrived to the community around 2:45pm on medical bus escorted by facility staff member... is happy and seems to be taking the transition well...
Medical record lacked an admission "arrival" and "assessment" note to define the status of Resident at time of admission (orientation, vitals, skin condition, ambulatory status, and other pertinent observations).

On 02/24/16 at 9:00am, observed #181 preparing to leave for appointment. Certified Medication Aide stated Resident going to clinic appointment to receive IV (intravenous) medication.

Review of Resident Notes revealed no documentation of trips out of facility for IV medication administration. The medical record lacked documentation of the times, the dates, actions taken, results of the actions, how Resident traveled to appointment, and condition upon return to facility.

The Administrator failed to ensure #181's record contained documentation of all incidents, symptoms and other indications of illness or injury, including the date, time of occurrence,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3261	Continued From page 49 action taken, and results of the action. - Review of record revealed #180 admitted to facility 02/06/16 with diagnoses of Progressive dementia, Chronic ulcerative colitis, Hypertension, Migraines, Parkinson's, and Hyperlipidemia. The FCS of 02/06/16 assessed #180 in need of health care services with bathing, dressing, toileting, medication and treatment management, bladder incontinence, cognition, communication, falls, and impaired decision making. The 02/09/16 NSA/HSP documented #180 to receive health care services to address these identified health care needs. By review of record, Resident Notes: 02/09/16 - 2:18pm - first entry in record... a medication clarification order Medical record lacked an admission "arrival" and "assessment" note to define the status of Resident at time of admission (orientation, vitals, skin condition, ambulatory status, mode of arrival, persons accompanying Resident, response to admission, and other pertinent observations). On 3/01/16 at 11:57am, Corporate Compliance nurse #C confirmed #180 admitted to facility 02/06/16, and no documentation available. The Administrator failed to ensure #180's record contained documentation of all incidents, symptoms and other indications of illness or injury, including the date, time of occurrence, action taken, and results of the action.	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3261	Continued From page 50 - Review of record revealed #176 admitted to facility 8/17/07 with diagnoses of Dementia, Congestive heart failure, Benign prostatic hypertrophy, Cellulitis, Motor dysfunction, Sleep apnea, Motor dysfunction, Venous stasis, Coronary artery disease, and Hearing loss. The 9/08/15 FCS assessed #176 in need of health care services for medications and treatments, with short term memory and memory recall impairment, with falls/unsteadiness, and used wheelchair. The 9/08/15 and 12/07/15 NSA/HSP's documented #176 to receive health care services for behaviors (occasional observation for safety and interactions with staff and others... observe for changes and report... has made inappropriate sexual statements towards others). The NSA/HSP lacked specific interventions to address this Resident's behaviors. (9/08/15 NSA/HSP included #176 receiving Depo injection monthly due to sexual behavior, but did not indicate who administered the injection). Resident Notes: 7/21/15 - 1:14pm - APRN (advance practice registered nurse) here to see Resident... new orders for injection medication every month for sexual behaviors... (no behaviors or interventions to address behaviors documented) 8/11/15 - 1:41pm - APRN here to see Resident, spoke with family member regarding continuing sexual behaviors (no behaviors or interventions to address behaviors documented) On 3/01/16 at 5:48pm, Administrator #B and Corporate LPN (licensed practical nurse) #D confirmed the medical record lacked	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3261	Continued From page 51	S3261		

documentation of the behaviors that prompted the pursuit of a physician's order for a hormone injection to curb behaviors.

The Administrator failed to ensure #176's record contained documentation of all incidents, symptoms and other indications of illness or injury, including the date, time of occurrence, action taken, and results of the action.

- Review of record revealed #183 admitted 02/28/13 with diagnoses of Dementia, Depression, Gastroesophageal reflux disease, Insomnia, Osteoarthritis, Hypertension, Coronary artery disease, and Degenerative joint disease.

The FCS of 8/14/15 and 11/12/15 assessed #183 in need of physical assistance with bathing, dressing, toileting, transfers, mobility, medication and treatment management, bladder incontinence, short term memory and memory recall impairments, communication impairment (rarely or never understands), with falls/unsteadiness, and used a wheelchair.

The 8/14/15 NSA/HSP documented #183 to receive health care services to address these identified health care needs.

Resident Notes:
4/04/15 - 2:13pm - Resident has had 3 falls in the past 24 hours (only one documented)... stated not in pain, no noticeable injuries... very confused and not at normal level of functioning... sent to hospital to assess for possible UTI (urinary tract infection)
Medical record lacked documentation of "three falls in 24 hours" to include the date, time, symptoms, indications of illness, injury, actions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3261	Continued From page 52 taken, and response to the actions. On 3/01/16 at 4:20pm, Administrator #B confirmed the medical record lacked documentation of three falls... contained a note on 04/03/15 at 4:32am of one fall, no other information documented. The Administrator failed to ensure #183's record contained documentation of all incidents, symptoms and other indications of illness or injury, including the date, time of occurrence, action taken, and results of the action.	S3261		